CENTERS FOR MEDICARE & MEDICAID SERVICES

PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a Recertification and State Licensure Survey. Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100 RE: Provider Number: 155191 Facility Number: 000100 AIM Number: 100266130 June 16th, 2011 Kim Rhodes, Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a Recertification and State Licensure Survey. This visit was for a Recertification and State Licensure Survey. FO000 This visit was for a Recertification and State Licensure Survey. Food of the provider Number: 155191 Facility Number: 000100 AIM Number: 100266130 June 16th, 2011 Kim Rhodes , Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER (X4) ID PREFIX TAG This visit was for a Recertification and State Licensure Survey. This view Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100 Facility number: 000100 Facility number: 000100 Facility number: 000100 This visit was for a Recertification and State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
WESTMINSTER HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F0000 This visit was for a Recertification and State Licensure Survey. Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a Recertification and State Licensure Survey. Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100 RE: Provider Number: 155191 Facility Number: 000100 AIM Number: 100266130 June 16th, 2011 Kim Rhodes, Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a Recertification and State Licensure Survey. Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100 RE: Provider Number: 155191 Facility Number: 000100 AIM Number: 100266130 June 16th, 2011 Kim Rhodes, Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a Recertification and State Licensure Survey. Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100	(5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DAY F0000 This visit was for a Recertification and State Licensure Survey. Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100 Facility number: 000100 Facility number: 000100 RE: Provider Number: 155191 Facility Number: 000100 AIM Number: 100266130 June 16th, 2011 Kim Rhodes, Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	ETION
This visit was for a Recertification and State Licensure Survey. Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100 RE: Provider Number: 155191 Facility Number: 000100 AIM Number: 100266130 June 16th, 2011 Kim Rhodes, Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	Έ
State Licensure Survey. Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility Number: 000100 AIM Number: 100266130 June 16th, 2011 Kim Rhodes, Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
State Licensure Survey. Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility Number: 000100 AIM Number: 100266130 June 16th, 2011 Kim Rhodes, Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100 Number: 100266130 June 16th, 2011 Kim Rhodes, Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
Survey Dates: May 23, 24, 25, 26, 27, 2011 Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100 Number: 100266130 June 16th, 2011 Kim Rhodes, Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100 Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
2011 Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
Facility number: 000100 Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
Facility number: 000100 Indianapolis, In 46204 Dear Ms. Rhodes Please find Form	
Facility number: 000100 Rhodes Please find Form	
Provider number: 155191 CMS-2567 with the plan of	
AIM number: 100266130 correction for the deficiencies	
sited during our recertification and	
Survey Team: Indiana State Licensure survey	
Conducted at Westiminster Health	
Avona Connell, RN TC Care Center on May 23rd through	
Donna Groan, RN May 27th, 20011. I can be reached at 812-282-9691 ext 123	
Dorothy Navetta, RN Claric Princet MCW if you would have any question or	
Gloria Reisert, MSW comments regarding the	
enclosed documents. Sincerely	
Census bed type: Floyd Shewmaker Administrator	
SNF/NF: 79 Westminster Health Care Center	
Residential: 84 Preparation and execution of	
Total: 163 this plan of correction do not	
constitute an admission or	
Cesus payor type: Addisors: 14	
Medicare: 14 the truth of the facts alleged or Medicaid: 35 conclusions set forth in the	
Other: 114 Total: 163 Statement of deficiencies. The plan of correction is prepared	
and / or executed solely	
Sample: 16 because it is required by the	
Supplemental sample: 08 provisions of federal and state	
Residential sample: 08 law. Allegation of Compliance:	
For the purposes of any	
These deficiencies also reflect state findings cited allegation the Westminster	
in accordance with 410 IAC 16.2. Health Care Center ("Facility")	
is not in substantial	
Quality review completed 6/6/11 by Jennie Bartelt, compliance with federal	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DTB611

Facility ID: 000100

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155191			A. BUILDING	LE CONSTRU 3 00		(X3) DATE SURY COMPLETE 05/27/2011	D
		100191	B. WING	DEET ADDRES	SS, CITY, STATE, ZIP CODE	03/21/2011	
NAME OF F	PROVIDER OR SUPPLIER				ITREE NORTH		
	NSTER HEALTH CA		CL		E, IN47129		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREF	IV (F	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE		(X5) OMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAC	CRC	DSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	RN.	,		red thi co We Ce	quirements of participations response and plan of rection constitute estminster Health Care enter allegation of mpliance.Date of mpliance:June 26th, 2011		
F0248 SS=D	program of activitie accordance with the assessment, the in mental, and psych resident.	nterests and the physical, osocial well-being of each	F0248	Pia	an of Correction (F 248)		06/26/2011
	facility failed to a liked wheeling/w offered the opportunities is sample of 16. (Refindings include The clinical recorreviewed on 5/25 resident's diagnous not limited to, Aldepression. The the facility on 3/3 Activity Assessm completed by Activity Interest Walking/Wheelin Comments and Tesident Staff with the same of	rd for Resident #95 was 5/11 at 9:20 a.m. The ses included, but were excluded to 10/11. The Initial ment, dated 3/10/11, tivity Employee #1, so not limited to:	F0248	wires	hat correction (P 246) hat correction (P 246) hat corrective action(s) we accomplished for those sidents found to have been sected by the deficient actice; Resident # 95 is not ager at the facility. How other independents having the potent be affected by the same ficient practice will be sentified and what correctition(s) will be taken; 1. It is is is in the price of the price	ill en ner ial ve and that d and ded. d for ity nd	6/26/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155191	B. WING	 	05/27/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER	L.	l l		
MEGTA	NOTED HEALTH O	ADE OFNITED		GREENTREE NORTH	
WESTMI	NSTER HEALTH C	ARE CENTER	CLAR	KSVILLE, IN47129	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	entertainment an	d social stimulated (sic).		and as needed. 3. Offer act	vities
		her to and from any		that meet the individual need	ds
		· ·		and interest of each resident	
	activities of her	choice.		found not met. 4. All staff to	
				encourage, invite, escort an	d
	The Activity Dir	ector provided the March		assist resident with activities	
	2011 Activity Ca	alendar on 5/27/11 at		interest per schedule. What	
	10:30 a.m. From March 10 thru March			measures will be put into p	• • • • • • • • • • • • • • • • • • •
22, 2011, a walking/wheeling outdoors				or what systematic change	
				will be made to ensure that	the
activity was not scheduled.				deficient practice does not	
				recur; 1. Activities will be off	• • • • • • • • • • • • • • • • • • •
In interview with the Activity Director on				and scheduled according to	• • • • • • • • • • • • • • • • • • •
5/27/11 at 10:30 a.m., he indicated the			of Care to meet all residents		
		-		individual needs and interes	t per
		an for activities was		resident's interest and or	
	standard and had	not been individualized		resident's activity assessme	• • • • • • • • • • • • • • • • • • •
	to Resident #95's	s specific interests. The		upon admission and reviewe	• • • • • • • • • • • • • • • • • • •
	care plan had no	t been updated since		least quarterly 2. Care Plar	is will
	admission.	oven up union since		be personalized upon initial	
	aumission.			interest assessment to meet	
				individual needs and interes	Torall
	3.1-33(a)			residents. Activity staff will	
				complete initial interest assessment upon admission	and
				review at least quarterly or a	• • • • • • • • • • • • • • • • • • •
				needed to assure resident's	3
				needs are being addressed.	
				Those Activities identified wi	ll be
				cross-referenced to the Activ	
				Calendar to assure the inter	· I
				the residents are being met.	
				Care Plans will be reviewed	
				every every quarterly assess	sment
				period, Annually and as	
				needed. Caer planswill be re	vised
				based on residents likes/ dis	likes
				and changes in their persona	
				needs and interest. How the	
				corrective action(s) will be	
				monitored to ensure the	

PRINTED: 06/20/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155191	A. BUILDING	00	COMPLETED 05/27/2011
	PROVIDER OR SUPPLIER		2210 G	ADDRESS, CITY, STATE, ZIP CODE REENTREE NORTH SVILLE, IN47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				deficient practice will not re i.e., What Quality Assurance program will be put into pla 1. Resident Care Plans will be reviewed by the Director of Activities & Interdisciplinary every quarterly assessment period, Annually and as nee to assure resident needs and interest are being met. All Carlon Plans will be reviewed at lead quarterly by the Interdisciplin Team. 2. Director of Activities monitor monthly participation records of all residents and adjustments to personalize adjustments to personalize and Plans and Monthly Schedule Activities to meet the needs interest of all residents. 3. Director of Activities will document in residents prograntes any changes of need, interest or participation pertato Activities of interest. By date will the systemic chanwill be completed. 06/26/11	re ace; pe Team ded d are st nary es will on make Care ed and ess sining what uges
F0250 SS=D	social services to a highest practicable psychosocial well-Based on record facility failed to assisted the interplanning and revalue a resident at risk elopement from the social services as a service and services are services as a services are services are services as a services are services as a services are services as a service are services as a service are services as a service are services are services as a service are services as a service are services are services as a service are services as a service are services are services as a service are services as a service are services are services as a service are services are services as a service are services as a service are services are services as a service are services are services as a service are services as a service are services are services as a service are services as a service are services are services are services as a service are services are services are services as a service are services are services are services as a service are services are services as a service are services as a service are services are services are services as a service are services are services are services are services as a service	rovide medically-related attain or maintain the ephysical, mental, and being of each resident. review and interview, the ensure social services disciplinary team in ising the plan for care of for and with history of the facility for 1 of 5	F0250	F2503.1-33(a)483.15(g)(1) PROVISION OF MEDICALL RELATED SOCIAL SERVICESWhat corrective action(s) will be accomplished those residents found to have been effected by the deficier practice: 1. A review of each	ed for re nt
	assistance in a sa	ed for social service mple of 16. (Resident at practice had the potential to		current resident's chart (that been targeted as at risk for elopement) will be complete review past interests and to	have

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DTB611

Facility ID:

000100

If continuation sheet

Page 4 of 41

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155191 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE NORTH WESTMINSTER HEALTH CARE CENTER CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE effect 5 additional residents identified by the ensure these (past interests) will be added or included in their care Director of Nursing as an elopement risk and plan which may include activities wearing a wanderguard. (Resident #6, 13, 24, 65, which may assist in decreasing wandering behaviors.2. The review and addition of past Findings include: interests being added to care plans (for those residents The clinical record for Resident #95 was reviewed considered an elopement risk) will on 5/25/11 at 9:20 a.m. The resident diagnoses be ongoing to include all those included, but were not limited to, Alzheimer's future residents as well.3. dementia and depression. The resident was Resident # 95 was discharged to admitted to the facility on 3/10/11. The Initial a secured Nursing Facility for her safety. How other residents Wandering Assessment Guide, dated 3/10/11, having the potential to be affected indicated the resident should have a 90 day by the same deficient practice will signaling device (Wanderguard) on for assessment be identified and what corrective purposes. Wandering behaviors can increase with action will take place:1. A meeting changes in residence, so consider monitoring the of the Interdisciplinary Team will resident until the next assessment period or until be held when residents have you can determine the elopement risk has increased exit seeking behaviors. decreased..." This is to include those already considered at risk for elopement The Social History & Assessment form completed and those that may be exhibiting on 3/17/11 by the Social Service Director, new exit seeking behaviors. The included but was not limited to, VII (7) care plan is to be updated and Resident's Special Interests: "outdoors" VIII (8). reviewed to include possible Mental Status Cognitive Alert; Short-Term areas of past interest to assist in Memory Poor; XII (12) Adjustment "doing okay decreasing exit seeking but wishes to go home" behaviors.2. A review of each resident's chart (that have been Nurses Notes, reviewed at this time, included, but targeted as at risk for elopement) were not limited to: 3/14/11 1600 (4 p.m.) "Res will be completed by Social attempted to get out of front door this shift. Services to ensure past interests Asking 'Is this how I get to the 3rd floor?'... Will are utilized as possible cont. (continue)to monitor for exit seeking." interventions to decrease exit seeking or wandering behaviors. 3/16/11 1600 "Res. is very confused and will exit 3. This is to be ongoing to include seek @ times. Res wheeled herself to the front all future residents targeted as door this shift and stood up from w/c being at risk for elopement as (wheelchair)..." well. What measures will be put into place or what systemic

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DTB611

Facility ID:

000100

If continuation sheet

Page 5 of 41

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155191 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE NORTH WESTMINSTER HEALTH CARE CENTER CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 3/18/11 8 p "[family member] wants exit seeking changes will be made to ensure that the deficient practice does behavior discussed with Dr. [named] on visit Tues. not recur: 1. When residents 3/22/11." (new to the facility and also those already here considered an 3/19/11 1300 (1 p.m.) "...Short term memory is elopement risk) begin exit very poor. Res gets up from w/c and ambulates ad seeking or increase exit seeking lib. She needs constant reminder not to ambulate behaviors, the Interdisciplinary unassisted. She wanders to doors throughout shift Team will meet and review those and pushes on door till alarm sounds..." residents care plans to ensure activities and past interests are 3/20/11 7:30 pm "Res. left facility and was found included in residents care plans. on the porch of A.L (Assisted Living). Facility Immediate interventions will be policy was used to search for resident. D.O.N. implemented by Nursing staff (Director of Nursing) and Administrator notified. upon increased behavior prior to Dr. [named] notified. Son [named] was called and the meeting of Interdisciplinary told one on one observation had been initiated for Team to include the updating of residents safety. He agreed to stay with resident the resident's Care Plan. These through the night. Head to toe exam of resident interventions may include but not revealed no injury and that the wanderguard was limited to, toileting, food/fluids, missing from residents ankle. A new one was activities and physician placed on L (left) ankle." notification.2. Each resident considered an elopement risk will The Social Service Progress Notes begin with also be added to the behavior 3/17/11 which included, but were not limited to, books which are at each Nurses "care plan to be reviewed...She is wearing a Station. In those behavior books. wander guard bracelet as res. was frequently a interventions (to include past walker @ ALU (Assisted Living Unit) and spent interests) will be available for all much X inside with res varying cognition nursing staff to review as needed. The feels res needs to stay in the NF (Nursing Facility) Interdisciplinary Team will review for her own safety will care plan code cognition the Resident Behavior Plans and desire to return home..." On 3/22/11 social monthly and as needed and changes will be made as services noted that the resident had left the facility appropriate. All Staff will be to go to her apartment. Inserviced by 6/26/2011 regarding the Behavior Management Policy The Resident Care Plan dated 3/10/11 included. and Procedures. 3. Monthly but was not limited to: "Needs/Problems Res. at elopement drills are to be risk for elopement; Goal/Objective Res will have conducted by Social Services no episodes of unknown whereabouts's daily thru Director to ensure staff know how next review; Approach/Action/Plan wanderguard to react in the event an actual in place, update wandering assessment quarterly elopement were to occur. The

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DTB611

Facility ID:

000100

If continuation sheet

Page 6 of 41

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155191 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE NORTH WESTMINSTER HEALTH CARE CENTER CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE and prn (as needed), update elopement manual, Elopement Policy and Procedure check placement & functioning of wanderguard as will be Inserviced by 6/26/2011. How the corrective scheduled on MAR (Medication Administration action(s) will be monitored to Record). Documentation was lacking the resident ensure the deficient practice will care plan had been revised prior to and after the not recur ie what QA program will elopement. be put into place: 1. Social Services Director will review all Review of the Social Service Director job residents targeted as an description dated July 17, 2007, provided elopement risk each month. The on 5/27/11 at 8:20 a.m., by the staff review will include the Elopement development coordinator, included, but Books and Behavior Books. During that review Social was not limited to: "Purpose: The Social Services will be responsible for Service Director will assure that the seeing that past interests are medically related emotional and social included in the Care Plan needs of the resident are interventions and also at that time Nurses Note and Behavior Book attained/maintained on an individual to be reviewed for effectiveness basis...Responsibilities...15. Is of the current interventions. This responsible for overseeing elopement is to be a part of our QA program and the findings reported at QA prevention protocols including the meeting monthly.2. Monthly elopement book...23. Will maintain a Elopement Drills to be held by productive working relationship with Social Services. This will be a other department supervisors and part of our QA program and the results of those drills (how staff coordinate social services to assure that responded, any concerns etc.) daily social services can be performed will be reported monthly in our QA without interruption and ensure that a meetings. By what date the team effort is achieved in developing a systemic changes will be completed: 6/26/11 comprehensive plan of care...37. Is responsible for developing a thorough, accurate, and comprehensive resident assessment of psychosocial needs through chart review and resident observation on all admission, significant changes, discharges, quarterlies, and as needed according to and within the time frame specified by current state and federal rules

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DTB611

Facility ID:

000100

If continuation sheet

Page 7 of 41

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2	2) MULTIPLE CO			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Α.	BUILDING	00		COMPL	
		155191	В.	WING			05/27/2	UTT
NAME OF F	ROVIDER OR SUPPLIER			I	ADDRESS, CITY, STAT			
					REENTREE NOF			
WESTMI	NSTER HEALTH CA	ARE CENTER		CLARK	SVILLE, IN47129			
(X4) ID		TATEMENT OF DEFICIENCIES		ID		AN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED	ACTION SHOULD BE O TO THE APPROPRIAT CIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFIC	SIENC I)		DATE
		and per facility policy						
	•	38. Is responsible for						
	developing a thro	•						
	-	and individualized						
	•	n on all admissions,						
	significant chang	-						
	-	is needed according to						
		me frame specified by						
	current state and							
		per facility policy and						
	•	plan of care should						
	reflect possible or identified							
	problems//needs of the resident and the							
	goals to be accon	nplished for each						
	problem identifie	ed. 39. Is responsible for						
	ensuring that con	nplete, accurate, and						
	comprehensive S	Social Service progress						
	notes that are cor	mpleted on all						
	admissions, signi	ificant changes,						
	discharges, quart	erlies and as needed						
	according to and	within the time frame						
	that is specified b	by current state and						
	federal rules and	regulations, and per						
		d procedures. 40. Will						
	review nurses' no	ote and other disciplinary						
		ne if the plan of care is						
		Will report problem						
	areas to the Direc							
	Services"	Č						
	In interview with the	e Social Service Director on						
		n. indicated the care plan was						
	not revised and upda	ated.						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID	DTB6	611 Facility	ID: 000100	If continuation sh	eet Pa	ge 8 of 41

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155191	B. WING			05/27/2	011
					DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			2210 GF	REENTREE NORTH		
WESTM	INSTER HEALTH C	ARE CENTER	CLARKSVILLE, IN47129				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
F0280 SS=D	incompetent or oth incapacitated under participate in plant changes in care at the comprehensive developed within to the comprehensive developed within to the comprehensive developed within to the comprehensive an interdisciplir attending physicial responsibility for the appropriate staff in by the resident's managed resident's family representative; and revised by a team each assessment. Based on record interview, the fact care plan was revised to and/or cutting of of 16 sampled resident's managed resident's managed resident's diagnoresident's	care plan must be 7 days after the completion sive assessment; prepared hary team, that includes the n, a registered nurse with he resident, and other n disciplines as determined heeds, and, to the extent hitricipation of the resident, ly or the resident's legal d periodically reviewed and of qualified persons after review, observation and heility failed to ensure the hitricipation of the resident's head to exit seeking for the Wanderguard for 2 hitricipation of the resident's helated to exit seeking for the Wanderguard for 2 hitricipation and heility failed to ensure the hitricipation and	F0:	280	F280 483.20(d)(3),483.10(k) Right to participate plannir Care-Revise CP The facility use the Risk to Wander Assessment to determine t need for a comprehensive of care for each resident. comprehensive plan of care will be developed immediat by the nurse after the completion of the Risk to Wander assessment that indicates the risk to wander when the resident exhibits wandering/ exit seeking behavior. The plan of care be prepared by the nurse	ng will he plan The e ely	06/26/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155191	B. WIN			05/27/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PRO	OVIDER OR SUPPLIER			1	REENTREE NORTH	
WESTMINS	STER HEALTH CA	ARE CENTER			SVILLE, IN47129	
					OVILLE, INTI 123	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		DATE
	•	resident was admitted to			immediately. The	
t	the facility on 3/1	10/11.			interdisciplinary team, and	
					other appropriate staff in disciplines as determined b	
1	Nurses Notes rev	riewed at this time,			the residents needs, and th	
l i	included, but wer	re not limited to: 3/14/11			extent practicable, the,	
	•	Res attempted to get out			participation of the residen	t.
I .		shift. Asking 'Is this			the residents family or the	"
		· ·			residents legal representati	ive
I .	_	Brd floor?'Will cont.			will periodically review and	
[((continue) to monitor for exit seeking."				revise the comprehensive p	olan
					of care. The facility will dev	elop
3	3/16/11 1600 "Res. is very confused and				a comprehensive plan of ca	•
1	will exit seek @ times. Res wheeled				for each resident with a his	tory
1	herself to the front door this shift and				of removing their Wander	
	stood up from w/c (wheelchair)"				Guard device. The	
	stood up Iroin w	• (\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			comprehensive plan of care	•
	2/10/11 0 n "[fam	aily mambarl wanta avit			will be developed by the nu immediately after identifica	•
		nily member] wants exit			of the intent to remove or the	
I .	_	discussed with Dr.			history of removal of Wand	
	[named] on visit	Tues. 3/22/11."			Guard device. The	-
					interdisciplinary team, and	
3	3/19/11 1300 (1 ₁	p.m.) "Short term			other appropriate staff in	
1	memory is very p	ooor. Res gets up from			disciplines as determined b	y
,	w/c and ambulate	es ad lib. She needs			the residents needs, and th	e
	constant reminde	er not to ambulate			extent practicable, the,	
1		wanders to doors			participation of the residen	t,
		and pushes on door till			the residents family or the	
I .	alarm sounds"	•			residents legal representati	
'	arariii Soulius				will periodically review an revise the comprehensive	I
	2/20/11 7 22	WD 1 0 C 1111			of care. CORRECTIVE	Pian
I .	•	"Res. left facility and			ACTION: For those residen	ts
I .		porch of A.L (Assisted			found to be affected by the	
]	Living). Facility	policy was used to			alleged deficient practice:	
5	search for resider	nt. D.O.N. (Director of			Resident # 95 This resident	was
1	Nursing) and Adı	ministrator notified. Dr.			discharged from our facility o	•
	•	. Son [named] was			03/22/2011. Resident #8	
1 '		ne on one observation			Risk to Wander assessment	was

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155191 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE NORTH WESTMINSTER HEALTH CARE CENTER CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE updated on June 3rd, 2011. The had been initiated for residents safety. He combination of the categories agreed to stay with resident through the indicated the resident is at risk to night. Head to toe exam of resident wander. He also has a history of revealed no injury and that the removing his Wander Guard device. The plan of care was Wanderguard was missing from residents updated to include a Wander ankle. A new one was placed on L (left) Guard device to the right hand ankle." Documentation was lacking of a and to the base of the residents 1:1 tracking log. wheel chair. All current residents identified as at risk to wander and with a history of removal of Wander Guard have had an The Resident Care Plan dated 3/10/11 updated Risk to Wander included, but was not limited to: assessment completed and care "Needs/Problems Res. at risk for plans reviewed and updated if needed for both. To identify elopement; Goal/Objective Res will have other resident's having the no episodes of unknown whereabouts's potential to be affected by the daily thru next review; alleged deficient practice:All Approach/Action/Plan Wanderguard in residents have the potential to be affected by the alleged deficient place, update wandering assessment practice. Nurse managers will quarterly and prn (as needed), update review all care plans for those elopement manual, check placement & residents identified at risk to functioning of Wanderguard as scheduled wander / exit seeking by the on MAR (Medication Administration completion of the risk to wander assessment or with a history of Record). Documentation was lacking the removing their Wander Guard resident care plan had been revised after device. A Comprehensive care the elopement nor after the increase in plan will be in place immediately exit seeking. when identified as at risk to wander. The plan of care will be reviewed by interdisciplinary 2. The clinical record for Resident #8 was team, and other appropriate staff reviewed on 5/24/11 at 10 a.m. The in disciplines as determined by the residents needs, and the resident's diagnoses included, but were extent practicable, the, not limited to, dementia and cerebral participation of the resident, the vascular disease. On 5/26/11 at 10:30 residents family or the residents a.m., Resident #8 was seated in a legal representative, and wheelchair. During interviw at this time, periodically reviewed and revised

STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) D			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155191	B. WIN			05/27/2	011
		<u> </u>	P		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R		1	REENTREE NORTH		
WESTM	INSTER HEALTH C	ARE CENTER			SVILLE, IN47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ed to locate the resident's			by a team of qualified perso		
	Wanderguard. S	he was observed			after each assessment. The corrective action will be	•	
	searching the res	sident's wrists, ankles and			monitored to ensure the		
	wheelchair for V	Vanderguard. The			alleged deficient practice of	loes	
	Wanderguard co	uld not be found. In			not recur: The Nurse Mana		
	1	LPN #3 at 10:35 a.m., she			will audit the 24 hour sheets	-	
		ident "likes to remove			to review all episodes of	-	
		ard). He cuts them off."			wandering or removing the		
	unem (wanderge	lard). The edis them on.			Wander Guard. With each		
	The Resident Care Plan dated 3/22/11				episode the plan of care will immediately reviewed to en		
	1				new intervention is in place.		
	indicated "Needs/Problems: Res. at risk				measures put in place to	IIIC	
	for elopement; Goal/Objective: Res will				ensure the alleged deficier	nt	
	have no episodes of unknown				practice does not recur: Al		
	whereabouts dai	ly thru next review;			licensed staff will be in-serv		
		n/Plan: Wanderguard in			by the Director of Nursing of	n	
		andering assessment			June 15th and June 16th, 2	011	
	1	prn (as needed), update			and Staff Development		
	1 * * * *	* ' *			Coordinator on June 22nd a		
	_	al, check placement &			June 24th, 2011 on the Poli	cy and	
		derguard as scheduled on			Procedure for developing comprehensive care plans f	or	
	MAR.				those residents at risk to wa		
	Documentation ¹	was lacking of a problem			or who have a history of ren		
	and intervention	s for the resident cutting			their Wander Guard device.	-	
	off his Wanderg	uard.			These in-services include the	e	
					requirement to develop	_	
	On 5/27/11 at 12	2:35 p.m., the Director of			immediately on identification		
		d the undated Policy and			risk of wander and removal		
	1 ~ .	are Plans which included,			Wander Guard and to update plan of care with a new	ile uile	
					intervention after each episo	ode of	
	1	ted to, "Care Plans -			wandering /exit seeking and		
	Preliminary Poli	-			each time the resident remo		
	preliminary plan				their Wander Guard device.	The	
	developed for ea	nch resident admitted.			findings of wandering / exit		
	Policy interpreta	tion and implementation			seeking or removing Wande		
	1 .	t the resident's immediate			Guard device will be reported		
		net and maintained a			the DON weekly. The DON	UI	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155191	B. WIN			05/27/2	011
	PROVIDER OR SUPPLIER			2210 GF	DDRESS, CITY, STATE, ZIP CODE REENTREE NORTH SVILLE, IN47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\top	ID	DO CHERTRIA DE LA CORRESCIONA		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		-	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	_	DATE
	admissionCare Comprehensive	4. Care plans are es in the resident's			designee will report finding or audits on a monthly basis to Quality Assurance Committee Effectiveness of plan: Facili Quality Assurance Committee monitor the corrective action monthly basis to assure the alleged deficient practice doe not recur. Any revisions or changes needed will be revie by the Quality Assurance Committee, Administrator, Do	the e. ty e will on a es	
F0323 SS=E	environment remain hazards as is possible receives adequated devices to prevent Based on recolumntation and observation to supervise a elopement to puilding. The a Wanderguard used to alert stexit (Resident failed to plant resident's habit Wanderguard, for elopement	on, the facility failed a resident at risk for brevent her exiting the resident was wearing dalarming device aff to unsupervised #95) The facility also for care related to the tof removing the for a resident at risk who used a to alert staff to	F0	323	3.1-35(d)(1) 3.1-35(d)(2)(A) 3.1-35(d)(2)(B) F323 483.25 FREE OF ACCIDENT The facility must ensure that the resident environment remai as free of accident hazards is possible and each reside receives adequate supervis and assistance devices to prevent accidents. Correctiv Action: For those residents found to be affected by the alleged deficient practice. Resident # 95 was discharge from our facility on 03/22/201 Resident #8. This resident h history of removing his Wand Guard device. The comprehensive plan of care	s(h) eins as nt iion ve s ed 11. as a	06/26/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155191 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE NORTH WESTMINSTER HEALTH CARE CENTER CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE will be developed by the nurse building. The deficient practice immediately after identification affected 2 of 4 residents reviewed of the intent to remove or the related to elopement in a sample of history of removal of the Wander Guard device. The 16 (Resident #95 #8) The deficient interdisciplinary team, and practice had the potential to affect 5 other appropriate staff in of 5 residents in a supplemental disciplines as determined by the residents needs, and the sample of 8. (Resident #6, 13, 24, extent practicable, the, 65, 45)participation of the resident, the residents family or the residents legal representative, Findings include: will periodically review and revise the comprehensive plan of care. Resident #8 The Risk to 1. The clinical record for Resident Wander Assessment was #95 was reviewed on 5/25/11 at updated on June 3rd, 2011. The combination of the categories 9:20 a.m. The resident diagnoses indicated the resident is at risk to included, but were not limited to, wander. He also has a history of removing his Wander Guard Alzheimer's dementia and device. The plan of care was depression. The resident was updated to include a Wander admitted to the facility on 3/10/11. Guard device to the right hand, to the shoe strings of the The Initial Wandering Assessment residents right shoe and to the Guide dated 3/10/11 indicated the base of the residents wheel chair. All current residents identified as resident should have a 90 day at risk to wander and with a signaling device on for assessment history of removal of a Wander Guard have had an updated Risk purposes. Wandering behaviors can to Wander assessment increase with changes in residence, completed and plan of care so consider monitoring the resident reviewed and revised if needed for both. The facility has updated until the next assessment period or all exit door alarm systems. All until you can determine the exit doors have had installed 1) A Wander Guard device at all exit elopement risk has decreased..." doors and transition breezeway. 2) Voice alert system to identify

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155191 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE NORTH WESTMINSTER HEALTH CARE CENTER CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE over head the door alarm that has The Social History & Assessment been activated. 3) A yellow form completed on 3/17/11 by the blinking light in ceiling at the door Social Worker, included but was that the door alarm has been activated. 4) A STI-Exit Stopper not limited to, VII (7) Resident's that will sound an additional alarm Special Interests: "outdoors" VIII of a louder and obviously different alarm sound. 5) A pass key alarm (8). Mental Status Cognitive Alert; key pad to release one door Short-Term Memory Poor; XII (12) alarm system to avoid alarm Adjustment "doing okay but wishes activation. The pass key is changed each month to a new to go home" pass key. 6) Light alert system at Skilled and ICF nursing stations to identify the door that has been A History & Physical dated 3/16/11 activated. A Wander book will be included, but was not limited to: placed at the both nursing units, ALU unit along with the Village "Patient was recently admitted for Receptionist to assist with rehab vs. long-term care...She has identification of all residents at risk to wander. Each of the above exhibited a great deal of exit door alarms work together and seeking behavior since coming failure to bypass any of these and open the door will activate the here. She is extremely pleasant but other alarms. These alarms will continues to try to leave the facility. not reset until a staff member responds to the activated door In fact, while I was here she tried to and uses a key or reset code key slip out the front door...Assessment for each alarm system. The and Plan...If she continues with her Wander Guards are a 90 life day system. These are changed exit seeking behavior then we will every 90 days and PRN by have to pursue a locked unit for her nursing. The Wander Guard active devices are assessed safety. However, we will give her a each shift by the charge nurse for chance to adjust and continue to efficacy. The Wander Guard door system and additional door follow." alarms are evaluated weekly by Maintenance. Any performance issues will be corrected Nurses Notes, reviewed at this time, immediately. To identify other included, but were not limited to: resident's having the potential

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155191	B. WIN	NG		05/27/2	011
NAME OF	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
THINE OF	NO VIDER OR SOLVER			1	REENTREE NORTH		
WESTM	INSTER HEALTH C	ARE CENTER		CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	3/14/11 1600	(4 p.m.) "Res			to be affected by the allege		
	attempted to get out of front door				deficient practice: All reside have the potential to be affect		
	this shift. Asking 'Is this how I get				by the alleged deficient pract		
		r?'Will cont.			Nurse managers will review	all	
					care plans for those resident		
	(continue) to monitor for exit				identified at risk to wander /		
	seeking."				seeking by the completion of risk to wander assessment o		
	3/16/11 1600 "Res. is very confused and will exit seek @ times. Res wheeled herself to the				with a history of removing the		
					Wander Guard device. A		
					Comprehensive care plan wi	ll be	
					in place immediately when	_	
					identified as at risk to wande The plan of care will be revie		
	front door this shift and stood up from w/c (wheelchair)"				by interdisciplinary team, an		
					other appropriate staff in		
	`	,			disciplines as determined by		
	2/10/11 0 m !!F.	fomily monahoul			residents needs, and the ext		
		family member]			practicable, the, participation the resident, the residents fa		
	wants exit see	-			or the residents legal	'''iy	
	discussed with	n Dr. [named] on visit			representative, and periodica	ally	
	Tues. 3/22/11.	"			reviewed and revised by a te		
					of qualified persons after each		
	2/10/11 1200	(1) !! Cla and dames			assessment. The corrective		
		(1 p.m.) "Short term			action will be monitored to ensure the alleged deficien	.	
	memory is vei	ry poor. Res gets up			practice does not recur: Th		
	from w/c and	ambulates ad lib. She			Nurse Manager will audit the		
	needs constan	t reminder not to			hour sheets daily to review a		
		ssisted. She wanders			episodes of wandering or		
					removing the Wander Guard		
		ghout shift and			With each episode the plan of care will be immediately revi		
	pushes on doo	or till alarm sounds"			to ensure a new intervention		
					place. A resident change for		
	3/20/11 7·30 r	om "Res. left facility			will be completed to alert all		
	1				Department Managers of the		
		d on the porch of A.L			instillation of or removal of a		
	(Assisted Livi	ng). Facility policy			Wander Guard device. The		

NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG TAG TAG TAG Was used to search for resident. D.O.N. (Director of Nursing) and Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., STRECT ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTRE NORTH CLARKSVILLE, IN47129 STRECT ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTRE NORTH CLARKSVILLE, IN47129 STRECT ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTRE NORTH CLARKSVILLE, IN47129 CARLSTORIAN CORPORATE CORP. STRECT ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTRE NORTH CLARKSVILLE, IN47129 CARLSTORIAN CARLSTORIAN CORPORATE COMPLETION CROSS-REPERTOR TOR. PREFIX TAG RECTITE CORP. CARLSVILLE, IN47129 CARLSTORIAN CARLSTORIAN CARLSTORIAN CARDS CITY, STATE, ZIP CODE 2210 GREENTRE NORTH CLARKSVILLE, IN47129 CARLSTORIAN CARLSTORIAN CARDS CITY, STATE, ZIP CODE 2210 GREENTRE NORTH CLARKSVILLE, IN47129 CARLSTORIAN CARLSTORIAN CARDS CITY, STATE, ZIP CODE 2210 GREENTRE NORTH CLARKSVILLE, IN47129 CARLSTORIAN CARDS CARLSTORIAN CARDS CITY, STATE, ZIP CODE 2210 GREENTRE NORTH CLARKSVILLE, IN47129 CARLSTORIAN CARDS CARLSTOR	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICINCY MUST BE PERCEDIED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Was used to search for resident. D.O.N. (Director of Nursing) and Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTEN CONTRIB COMPLETION DATE Date of the precision of contribution of the policy of the contribution of the plan of care with a new intervention after each episode of wandering / exit seeking and for each time the resident removes their Wandering / exit seeking and for each time the resident removes their Wandering / exit seeking and for each time the resident removes their Wandering / exit seeking and for each time the resident removes their Wandering / exit seeking and for each time the resident removes their Wandering / exit seeking and for each time the resident removes their Wandering / exit seeking and for each time the resident removes their Wandering / exit seeking or removing Wander Seeking o	AND PLAN	OF CORRECTION		A. BUI	LDING	00		
WESTMINSTER HEALTH CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG Was used to search for resident. D.O.N. (Director of Nursing) and Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for resident safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. Westminstrater REALTH CARE CENTER 2210 GREENTREE NORTH CLARKSVILLE, IN47129 (X5) PREFIX (CARKSVILLE, IN47129 ID PREFIX (CARKSVILLE, IN47129 (X5) PREFIX (CACH DEFICIENCY MUST Be percebed by the Levelopment consumers and complete to ensure the alleged deficient practice does not recur: All licensed staff will be in-serviced by the Director of Nursing on June 15th and June 16th, 2011 and Staff Development Coordinator on June 22nd and June 24th, 2011 and Staff Development Coordinator on June 22nd and June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the plan of care with a new intervention after each episode of wandering / exit seeking or removing Wander seeking seeking or removing Wander seeking seeking or removing Wander seeking seeking or removing Wander			155191	B. WIN	IG		05/27/2	011
CLARKSVILLE, IN47129	NAME OF I	PROVIDER OR SUPPLIE	· · · · · · · · · · · · · · · · · · ·					
CAS ID SUMMARY STATEMENT OF DEFICIENCIES TAG REQULATORY OR LSC IDENTIFYING INFORMATION) TAG REQULATORY OR LSC IDENTIFYING INFORMATION TAG REQULATORY OR LSC IDENTIFY OR COMPLETION CASCALLONG INCLEDES INCLUDE IN CASCALLONG INCLEDES INCLUDE	VALEDERAL	NOTED LIEALTILO	ADE OFNITED		1			
### PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) Was used to search for resident. D.O.N. (Director of Nursing) and Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., PREFIX TAG P	WESTMI	INSTER HEALTH C	ARE CENTER		CLARK	SVILLE, IN47129		
was used to search for resident. D.O.N. (Director of Nursing) and Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. Regulatorry or LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRATE DATE Regulatorry or LSC IDENTIFYING INFORMATION) TAG Regulatorry or LSC IDENTIFYING INFORMATION) TAG Regulatorry or LSC IDENTIFYING INFORMATION) Reasures put in place to ensure the alleged deficient practice does not recur: All licensed staff will be in-serviced by the Director of Nursing on June 15th and June 16th, 2011 and Staff Development Coordinator on June 22nd and June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander					I	PROVIDER'S PLAN OF CORRECTION		
was used to search for resident. D.O.N. (Director of Nursing) and Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. measures put in place to ensure the alleged deficient practice does not recur: All licensed staff will be in-serviced by the Director of Nursing on June 15th and June 16th, 2011 and Staff Development Coordinator on June 22nd and June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander		,			I	CROSS-REFERENCED TO THE APPROPRIAT	ΤE	
D.O.N. (Director of Nursing) and Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. ensure the alleged deficient practice does not recur: All licensed staff will be in-serviced by the Director of Nursing on June 15th and June 16th, 2011 and Staff Development Coordinator on June 22nd and June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander	TAG	1			TAG	<u>_</u>		DATE
Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., practice does not recur: All licensed staff will be in-serviced by the Director of Nursing on June 15th and June 16th, 2011 and Staff Development Coordinator on June 22nd and June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering / exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander		was used to se	earch for resident.					
Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. Administrator notified. Dr. [named] notified. Son [named] was by the Director of Nursing on June 15th and June 16th, 2011 and Staff Development Coordinator on June 22nd and June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander		D.O.N. (Direc	ctor of Nursing) and			_		
called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. June 15th and June 16th, 2011 and Staff Development Coordinator on June 22nd and June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander		Administrator	notified. Dr.			-		
called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering / exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander		[named] notified. Son [named] was						
observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., Coordinator on June 22nd and June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander)11	
residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander						•	1	
residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander								
Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander		residents safet	y. He agreed to stay				, - ·- 	
Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander								
revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander								
wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander							oving	
residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander							9	
residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander								
Documentation was lacking of a 1:1 tracking log. Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander		residents ankl	e. A new one was			immediately on identification	of	
Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., Wanter Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander		placed on L (1	eft) ankle."					
tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander		-					e the	
In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander			in was lacking of a 1.1			•	de of	
In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander		tracking log.						
Director on 5/26/11 at 10:40 a.m., findings of wandering / exit seeking or removing Wander						-		
Director on 5/26/11 at 10:40 a.m., seeking or removing Wander		In interview w	vith the Maintenance			their Wander Guard device.	The	
Seeking of removing wander		Director on 5/	26/11 at 10:40 a m					
1 1 - 1 - 1 1								
he measured the distance from the Guard device will be reported to the DON weekly. The DON or								
porch at the Assisted Living designee will report finding of		porch at the A	ssisted Living					
residence to the door near the audits on a monthly basis to the		residence to the	ne door near the					
smoke shack from which the Quality Assurance Committee. All		smoke shack t	from which the					
vander Guard audits will be								
							or of	
measured 403 feet. Maintenance and the Director of Nursing and reported monthly to		measured 403	feet.					
the Quality Assurance						- ·	,	
The Resident Care Plan dated Committee. Effectiveness of		The Resident	Care Plan dated			_	f	
3/10/11 included but was not plan: Facility Quality Assurance							nce	
Continued will monitor the								
limited to: "Needs/Problems Res. corrective action on a monthly							ly	
at risk for elopement; basis to assure the alleged deficient practice does not recur.		at risk for elop	pement;				ecur.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191		LDING	onstruction 00	(X3) DATE COMPI 05/27/2	ETED
NAME OF F	PROVIDER OR SUPPLIE			1	ADDRESS, CITY, STATE, ZIP CODE	•	
WESTMI	NSTER HEALTH C	ARE CENTER		1	REENTREE NORTH SVILLE, IN47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	· `	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	Any revisions or changes n	eeded	DATE
	l "	re Res will have no			will be reviewed by the Qua		
	l ⁻	nknown whereabouts			Assurance Committee, Administrator, DON, and		
	outs daily thru Approach/Act				Maintenance Director.		
	1	in place, update					
	1	sessment quarterly and					
	_	d), update elopement					
	manual, check placement &						
		f wanderguard as					
	scheduled on MAR (Medication						
	Administration Record).						
	Documentation was lacking the						
	resident care j	olan had been revised					
	after the elope	ement nor after the					
	increase in ex	it seeking.					
	family member p.m., he provide and/or his mother until so	with the resident's er on 5/26/11 at 12:30 ded a letter indicating nephew sat with his he was transferred. walk, be outside and on the porch at the ng.					
	Detail Report at 8:45 a.m., o	Behavior Symptoms provided on 5/26/11 lated March 10 thru 11, indicated, "None					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155191	B. WIN			05/27/2011	
NAME OF I	DROVIDED OD SLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	:		2210 G	REENTREE NORTH		
WESTMI	NSTER HEALTH C	ARE CENTER		CLARK	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		1
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE	DATE	\dashv
		iors apply." A					
		rovided at this time,					
	ŕ	was not limited to,					
	"Wandering;						
	resident's wan	dering; Was					
	wandering eas	ily altered?					
	Approximately	y what time did					
	wandering occ	eur?; Was diversion					
	effective for w	andering?"					
		n was lacking for the					
		ent was exit seeking.					
		% &.					
	2. The clinica	l record for Resident					
	#8 was review	ed on 5/24/11 at 10					
	a.m. The resid	lent diagnoses					
		were not limited to,					
	ŕ	cerebral vascular					
		/26/11 at 10:30 a.m.,					
		as observed seated in					
	a wheelchair.						
		ching the resident's					
	· ·	and wheelchair after					
		e the Wanderguard.					
		ard could not be					
	found. In inte	rview with LPN #3 at					
	10:35 a.m., sh	e indicated the					
	resident "likes	to remove them [the					
		. He cuts them off."					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155191	B. WIN	G		05/27/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MESTMI	NISTED HEALTH CA	ADE CENTED			REENTREE NORTH SVILLE, IN47129		
	NSTER HEALTH C				.5VILLE, IN47 129		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
	Signed and dat	ted 4/26/11					
	Signed and dated 4/26/11 Physician's Order for April 2011						
	_	was not limited to the					
	ŕ						
	_	randerguard check					
	_	function every					
	shift."						
	Review of the	Resident Care Plan					
	dated 3/22/11	indicated					
	"Needs/Proble	ems: Res. at risk for					
	elopement; G	oal/Objective: Res					
	_	pisodes of unknown					
	_	aily thru next review;					
	Approach/Act						
	* *	n place, update					
	_						
	_	essment quartly (sic)					
	and prn (as nee						
	elopement mai						
	placement & f						
	wanderguard a	as scheduled on					
	MAR.						
	Documentation	n was lacking of a					
	problem and in	nterventions for the					
	resident cuttin	g off his					
	wanderguard.	C					
	3 On 5/26/11	at 8:55 a.m., the					
		rrsing provided the					
	current list of i	residents utilizing a					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155191		A. BUILDING B. WING			COMPL 05/27/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE NORTH CLARKSVILLE, IN47129				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0364 SS=F	Residents #8, # #24, #65, and is 3.1-45(a)(2) Each resident receprovides food preparance; and fattractive, and at the Based on observation interview, the fact food was served temperatures for observations. The affected 5 of 6 resident interview (Resident #103, and #104) affect 79 of 79 remeals from the k Findings include During the confidence from the k Findings include the confidence from the k Findings inclu	eives and the facility pared by methods that value, flavor, and cood that is palatable, the proper temperature. In a proper temperature, and callity failed to ensure at appropriate 1 of 3 dietary this deficient practice sidents at the Group tents #100, #101, #102, and had the potential to sidents, who received itchen.	F0364		Tag F-364: Nutritive Value/Appear, Palatable/Pre Temp: Resident Concerns Corrective action for those residents affected by the alledeficiency Five of six resident stated that they were affected alleged deficiency. CDM che all six of these residents for significant weight loss, a noticeable decline in meal consumption and for compla of GI disturbance. No notab changes could be identified. Identify residents we have potential to be affected alleged deficiency and correct action for those residents. Al residents have potential to be affected by the alleged deficiency. Primary care stat have been interviewed to determine if any wide spread complaints of GI disturbance and none have been noted. In serviced staff on May 24,2	eged ints d by ints le who by ctive l e ff d ss CDM	06/26/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPL	ETED
		155191	B. WIN			05/27/2	011
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l .	
NAME OF I	PROVIDER OR SUPPLIEF	8			REENTREE NORTH		
WESTM	INSTER HEALTH C	ARE CENTER			SVILLE, IN47129		
				L	OVIELE, 11447 123		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	the food still was not always warm. The				on policy & procedure for tak	-	
	residents indicated the cold food occurred				temperatures on the healthca steam table. Temperatures a		
	whether they ate	in the main dining room			be taken and recorded 3 time		
	or in their rooms	- i.			each meal (before beginning		
					when they get to dining room		
	When asked if the	ney had brought this to the			at the end of service). The		
		r dietary manager's			in-service also included the p		
		, ,			and procedure on how to re-	heat	
	1	idents indicated they had			food to the appropriate		
	"	ident Council meetings			temperature. All cooks were		
	with Activity As	sistants #1 and #2, but			in-serviced on the appropriat holding temperature per the		
	nothing had been	n done about it. Review of			safe guidelines. Corrective ac		
	the February thro	ough May 2011 Resident			will be monitored to ensure the		
	Council minutes	failed to note			alleged defiant act does not		
		of the residents' concerns			occur. 1. All staff in-serviced	on	
		rature of the food.			May 24,2011 and to be		
	about the temper	ature of the rood.			in-serviced again on June		
	D : 4 1.1				17,2011 regarding appropria		
	1 -	exit meeting with the			temperature of foods and wh take temperatures2. Cooks v		
	1	nd the Director of Nursing			be monitored daily by CDM of		
	on 5/25/2011 at	12:20 p.m., they indicated			designee to ensure they are	"	
	they were not aw	vare there had been a			taking food temperatures. 3.	CDM	
	problem with the	e food not being warm			or designee will be doing dai		
	enough when ser	-			rounds to ensure cooks are		
					recording temperatures 3 tim	ies	
	On 05/24/11 at 7	:57 a.m., the breakfast			per meal and that these	rod	
	1	red being served in the			temperatures meet the requi temperature per the serve sa		
	1	_			guidelines.4. CDM or design		
	1	n. In interview with the			will record findings on a daily		
		, she indicated the food			audit sheet for 3 months and		
	1 -	re documented in the			randomly after that. Any devi		
	kitchen prior to l	oringing the steam table			will be corrected immediately		
	to the dining room. The Dietary Manager				responsible employee educa		
	was present at this time and indicated the				Audit and findings to be repo		
	food temperatures are also to be taken and documented when the steam table arrives				to the QA team in the monthl meeting.5. Director of Activiti		
					will report any resident conce		
					coming out of monthly resident		
	I in the dining roo	m and prior to service in			- coming out of monthly reside		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155191 05/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2210 GREENTREE NORTH WESTMINSTER HEALTH CARE CENTER CLARKSVILLE, IN47129 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE council meeting to CDM with a the dining room. The cook indicated she Resident Council Concern Form. failed to take temperatures after the steam CDM will respond on the table arrived in the dining room prior to appropriate form and return the serving. form to the Activity Director or designee after investigating the issue not to exceed five (5) The Dietary Manager instructed the cook to to take days. The CDM will be available the food temperatures at this time. The to answer questions regarding the temperature of the fried eggs measured 126.3 issue from the Resident Council Fahrenheit, the fried potatoes measured 107.3 F. in as requested by the Council. The one area of the steam table pan and 155.9 degrees Activity Director or designee will in another area of the same pan. When gueried as introduce the Resident Council to the appropriate temperature of the fried eggs, Concern Form at the next the cook indicated she did not know. scheduled Council Meeting to inform the Council of Action The dietary manager provided a copy of the Policy Taken. Effectiveness of the plan. & Procedure Food temperatures at 4:20 p.m., on Any revisions needed will be 05/24/11, which was reviewed at this time. Under evaluated by the QA team, Procedure: #3. "Temperatures of the food are to Dietary Manager, Consultant be taken again before you start serving the dining Dietician and the room...." Administrator. Tag F-364: **Nutritive Value/Appear.** 3.1-21(a)(2)Palatable/Prefer Temp: Food Temperatures Corrective action for those residents affected by the alleged deficiency No residents have been affected by alleged deficiency. Primary staff have been interviewed for complaints of GI disturbance. None have been reported. Identify residents who have potential to be affected by alleged deficiency and corrective action for those residents. All residents have potential to be affected by the alleged deficiency. Primary care staff have been interviewed to determine if any wide spread complaints of GI disturbances and none have been noted. CDM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155191		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE COMP 05/27/ 2	LETED	
	ROVIDER OR SUPPLIER		2210 GI	 .DDRESS, CITY, STATE, ZIP CODE REENTREE NORTH SVILLE. IN47129		
	NSTER HEALTH CA SUMMARY S (EACH DEFICIEN		STREET A	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PROVIDER'S PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD	24,2011 or taking althcare ares are to 8 times anning, aroom and the policy or e-heat vere apriate the serve are to 11 and on June apriate d when to obs will DM or are are s. 3. CDM doing ooks are	(X5) COMPLETION DATE
				recording temperatures per meal and that these temperatures meet the responsibilities. CDM or describe will record findings on a audit sheet for 3 months randomly after that. Any will be corrected immed responsible employee e Audit and findings to be to the QA team in the meeting. Effectiveness on plan. Any revisions need	required we safe signee daily and then deviation dately and ducated. reported onthly of the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155191	A. BUII	LDING	00	05/27/20	
		100101	B. WIN			03/21/20	711
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE REENTREE NORTH		
WESTMI	NSTER HEALTH CA	ARE CENTER	CLARKSVILLE, IN47129				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0371	The facility must -				evaluated by the QA team, Dietary Manager, Consultant Dietician and the Administrator. Completion Da 6/26/11		
SS=F	considered satisfal local authorities; a (2) Store, prepare, under sanitary con	distribute and serve food	F0	371	Tag F-371: Food Procure,		06/26/2011
		ensure hands were			SttioréPrepare/Serve	=	
	washed, equipme	ent was clean, rinse			· ·		
	temperatures wer	re 180 degrees in the			-Sanittiary		
	dishwasher, and l	hot food was served at			Floors and Hood Systtiem Correcttive acttion ftor ttihose resi	donttis	
	140 degrees Fahr	renheit (F) on 3 of 3			aftecttied by ttihe alleged deftcien		
	dietary observation	ons. This deficient			No residenttis have been aftecttied	1	
	practice had the p	potential to affect 79 of			alleged deftciency. Primary sttiaft		
	79 residents recei	iving meals from the			have been inttierviewed ftor		
	dietary departmen	nt.			complainttis oft GI disttiurband on have been reporttied	ne	
	Findings include:	:			Identtifty residenttis who have		
	On 05/22/11 1-4	rryaan tha harma -f0.46			pottienttial ttio be aftecttied by all	-	
		ween the hours of 9:46			deftciency and correcttive acttion thin the transfer of the tr	<u>π</u> or	
		m., the following was			All residenttis have pottienttial ttio	be	
	observed:				aftecttied by ttihe alleged deftcien	I	
	1 Th. d. ' C				Primary care sttiaft have been		
		cont of the grill, stove and			inttierviewed ttio dettiermine ift a	· I	
	_ -	with grease and pieces of			spread complainttis oft GI disttiurb	I	
		od over the stove was			and none have been nottiedCDM t in-service sttiaft on June 17,2011 or	I	
	_	dust and grease. In			importtiance oft keeping area and		
		e Assistant Dietary			ftoors clean atti all ttime s he		
		at this time she indicated			in-service will include ttihe		
	the hood is clean	ed every 2 weeks.			importtiance oft keeping ttihe hoo	d	
					systtiem ftree ftrom dustti and gre	ase	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED	
		155191	B. WIN			05/27/2	011	
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEF	₹		2210 GREENTREE NORTH				
WESTM	INSTER HEALTH C	ARE CENTER		CLARKSVILLE, IN47129				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	2. The Robot Co	oupe (used to puree food)			<u>-</u>			
	stored as clean was wet on the inner				Correcttive acttions will be monitt			
	surface. The AI	OM indicated the Robot			ttio ensure ttihe alleged deftantti	actti		
	Coupe is suppos	ed to stay on the drying			does notti occur.			
	shelf to drain and				Hood Venttis were ttiaken down	n and		
		u. j .			cleaned immediattiely 2. Floors will be sweptti and mopp	od.		
	2 The ringe term	proreture in the			randomly ttihrough outti ttihe day			
	3. The rinse tem	-			needed. The hood systtiem is on t			
		d to reach 180 degrees			biweekly cleaning schedule ttio	iciii c		
	Fahrenheit in tw	•			ensure a deep cleaning oft ttihe			
	_	ehed 160 degrees for 2			systtiem			
	cycles. The dish	washer indicated at this			3. CDM and/or designee will be			
	time the rinse ter	mperature should measure			doing daily auditti rounds ttio ens	ure		
	180 degrees.				ftoors are keptti clean and ttihe ho	ood		
					systtiem is ftree ftrom dustti and g	rease		
	4. Two steam ta	ble pans stacked together			CDM ttio monittior biweekly clean	ing		
	1	an were wet and soiled			schedules ttio ensure ttihey are be	eing		
	with food on the				cleaned appropriattiely			
	with food on the	inner surfaces.			4. CDM or designee will record			
	5 0 05/24/11	-4.7.57 C - 1 //1			ftndings on a daily auditti sheetti f			
	1	at 7:57 a.m., Cook #1,			monttihs and ttihen randomly afte ttihatfäny deviattion will be correc			
	1	e food temperatures at the			immediattiely and responsible	llieu		
	1 -	r to serving food. When			employee educattiedAuditti and			
	requested to mea	asure the temperatures at			ftndings ttio be reporttied ttio ttih	e QA		
	this time the frie	d eggs measured 126.3			ttieam in ttihe monttihly meetting			
	degrees F., and t	he potatoes measured						
	107.1 degrees F.	in one area of the pan			Eftecttiveness oft ttihe plan			
	1	another area of the same			Any revisions needed will be			
		k #1, was queried as to			evaluattied by ttihe QA ttieadiettia	ry		
	1 -	temperature of the fried			Manager, Consulttiantti Diettician	and		
	1	she replied she did not			ttihe Administtirattior			
		she replied she did not			-			
	know.				-			
					-			
	1	at 9:33 a.m., the			- 			
	following was o	bserved: the ceiling vent			Tag F-371: Food Procure	<u>.</u>		
	over clean dishe	s by the dish machine was						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155191		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SU COMPLE 05/27/20			ETED		
	ROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE REENTREE NORTH SVILLE, IN47129		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIENCE REGULATORY OR Soiled with heavy) 7. On 5/27/11 at the lid of the tras	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) y dust. 9:43 a.m., Cook #2, lifted h container and without ds the cleaned the prep		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) Sttior Prepare/Serve -Sanittiary Robotti Coupe Correcttive acttion ftor ttihose ress aftecttied by ttihe alleged deficier No residenttis have been aftecttie alleged deficiency. Primary stitiaft have been inttierviewed ftor complainttis oft GI disttiurbands on have been reporttied Identtifty residenttis who have pottienttial ttio be aftecttied by all deficiency and correcttive acttion tithose residents All residents have pottienttial ttic aftecttied by tihe alleged deficier Primary care stiaft have been inttierviewed ttio dettiermine ift a spread complainttis oft GI distitur and none have been nottiedCDM in-service stiaft on June 7,2011 o importtiance oft letting tihe robo coupe air dry and being sure itti is clean and complettiely dry beftore putting itti away	identtis icy d by ne egged ftor o be oxy ny wide oxnces ttio n tti e	(X5) COMPLETION DATE

PRINTED: 06/20/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/SCLIA IDENTIFICATION NUMBER: 155191	A. BUILDING B. WING	00	COMPLETED 05/27/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE NORTH CLARKSVILLE, IN47129				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				3. CDM and/or designee will be doing daily rounds ttio ensure all dishes including pottis, pans and robotti coupe are clean and dry 4. CDM or designee will record ftndings on a daily auditti sheetti it monttihs and ttihen randomly after ttihattiny deviattion will be correct immediattiely and responsible employee educattiedAuditti and ftndings ttio be reporttied ttio ttih ttieam in ttihe monttihly meetting and responsible evaluattied by ttihe QA ttiedDirettian Manager, Consulttiantti Diettician ttihe Administtirattior Tag F-371: Food Procure Sttion Prepare/Serve -Sanittiary Dishwasher Correcttive acttion ftor ttihose resulted by ttihe alleged deficier No residenttis have been aftecttied alleged deficiency. Primary striaft have been inttierviewed ftor complainttis oft GI distiturband work have been reporttied Identify residenttis who have pottienttial ttio be aftecttive acttion ttihose residenttis who have pottienttial ttio be aftecttive acttion ttihose residenttis have pottienttial ttio designed to the saftecttien acttion ttihose residenttis have pottienttial ttio designed to the saftecttien acttion ttihose residenttis have pottienttial ttio designed to the saftecttien acttion ttihose residenttis have pottienttial ttio designed action ttihose residenttis have pottienttial ttion to the saftect acttion ttihose residenttis have pottienttial ttion to the saftect acttion ttihose residenttis have pottienttial ttion to the saftect acttion ttihose residenttis have pottienttial ttion to the saftect acttion to the saftect acttion to the saftect action to the saftect	er ttied e QA gry and identtis ncy d by ine		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DTB611

Facility ID:

000100

If continuation sheet

Page 28 of 41

PRINTED: 06/20/2011 FORM APPROVED OMB NO. 0938-0391

	FOR DEFICIENCIES OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	A. BUII	LDING	00	COMPL 05/27/2	ETED
	ROVIDER OR SUPPLIE		P. 1111	STREET A	DDRESS, CITY, STATE, ZIP CODE REENTREE NORTH SVILLE, IN47129	l	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					aftecttied by ttihe alleged deftcient Primary care sttiaft have been inttierviewed ttio dettiermine ift a spread complainttis oft GI distitured and none have been nottiedCDM inservice sttiaft on June 7,2011 or importtiance oft rinse ttiemperattitie dishwasher The inservice wi include procedure ftor whatti ttio when ttihe dishwasher does nottititihe appropriattie ttiemperattiure. Correcttive acttions will be monitive ttio ensure ttihe alleged deftanttice does notti occur. 1. The dishwasher was empttied immediattiely and reftlled and ttiemperattiure was appropriattie ttime. Hobartti came in on May 23,2011 ttio check ttihe boosttier 2. Temperattiures are ttio be ttiake recorded on a ttiemperattiure log ttimes daily. 3. CDM and/or designee will be doing daily rounds ttio ensure dishwasher ttiemperattiures are reaching ttihe appropriattie ttiemperattiure 4. CDM or designee will record ftndings on a daily auditti sheettif monttihs and ttihen randomly after ttihatany deviattion will be correct immediattiely and responsible employee educattiedAuditti and ftndings ttio be reporttied ttio ttih ttieam in ttihe monttihly meetting Eftecttiveness oft ttihe plan	ny wide pances attio iure oft ill ill ill ill ill ill ill ill ill il	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CONSTRUCTION	(X3) DATI	ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COM	PLETED
		155191	B. WING		05/27/	2011
		l .	STR	EET ADDRESS, CITY, STA	TE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		221	0 GREENTREE NO	RTH	
WESTMI	NSTER HEALTH CA			ARKSVILLE, IN4712		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PI	LAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFI	CROSS-REFERENCE	'E ACTION SHOULD BE ED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFI	ICIENCY)	DATE
				Any revisions ne	eeded will be	
				evaluattied by tt	tihe QA ttie Dri ettiary	
				Manager, Consu	ulttiantti Diettician and	
				ttihe Administtir	rattior	
				-		
				-		
				-		
				<u>Tag F-371: F</u>	Food Procure,	
				Sttior é Prepa	are/Serve_	
				<u>-Sanittiar</u> y		
				Sttieam ttiable p	<u>oa</u> ns	
				Correcttive actti	ion ftor ttihose residenttis	
				aftecttied by ttih	ne alleged deftciency	
				No residenttis h	ave been aftecttied by	
				alleged deftcien	cy. Primary sttiaft	
				have been inttie	erviewed ftor	
				complainttis oft	GI disttiurbandeone	
				have been repor	rttied	
				Identtifty reside	enttis who have	
				pottienttial ttio l	be aftecttied by alleged	
				deftciency and c	correcttive acttion ftor	
				ttihose resident		
				All residenttis ha	ave pottienttial ttio be	
				aftecttied by ttih	ne alleged deftciency	
				Primary care stti	iaft have been	
				inttierviewed tti	io dettiermine ift any wide	
				spread complair	nttis oft GI disttiurbances	
				and none have b	been nottiedCDM ttio	
				in-service sttiaft	on Jun d 7,2011 on	
				importtiance oft	t making sure pottis and	
				pans are clean a	and dry beftore being	
				putti away		
				- Corroctivo octi	ions will be monittiored	
					e alleged deftantti actti	
				does notti occur		
				1. The triwo stric	eam ttiable pans were	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155191		A. BUILDING B. WING 00 CO! 05/2			ATE SURVEY MPLETED 27/2011	
	ROVIDER OR SUPPLIER		221	EET ADDRESS, CITY, STATE, ZIP CO 10 GREENTREE NORTH ARKSVILLE, IN47129	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETION DATE
				removed immediattiely an re-washed. 2. Potti and pan area will be monittiored daily by CDM ttio be sure ttihatti all potti robotti coupeare clean and complettiely dry beftore tt away. 3. CDM and/or designee we doing daily rounds ttio ensidishes including pottis, par robotti coupe are clean and 4. CDM or designee will reftndings on a daily auditties monttihs and ttihen rando ttihattiny deviattion will be immediattiely and response employee educattied Audit ftndings ttio be reporttied ttieam in ttihe monttihly mediattied by ttihe QA tties Manager, Consulttiantti Dittihe Administtirattion Tag F-371: Food Prosttion for ttil aftecttied by ttihe alleged No residenttis have been alleged deficiency. Primar have been inttierviewed ft complainttis oft GI distiur	e or designee iss and liney are putti will be ure all ins and didry cord sheetti for mly after e correcttied ible ti and titlo ttihe QA heetting in the capital sheettian and line sheet	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155191		(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPI 05/27/2	LETED	
	PROVIDER OR SUPPLIER		2210 G	ADDRESS, CITY, STATE, ZIP CODE		
WESTMI	NSTER HEALTH C	ARE CENTER	CLARK	SVILLE, IN47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
				have been reporttied Identtifty residenttis who har pottienttial ttio be aftecttied deftciency and correcttive act tithose residenttis All residenttis have pottientt aftecttied by ttihe alleged de Primary care stiaft have been inttierviewed ttio dettiermin spread complainttis oft GI diand none have been nottied in-serviced stiaft on Mar 4,2 policy & procedure fror ttiak ttiemperattiures on ttihe heastieam ttiable emperattiures ttiaker 8 ttimes each meal been beginning, when ttihey getti room and atti ttihe end oft so in-service also included ttihe and procedure on how ttio reftood ttio ttihe appropriattie ttiemperattiure all cooks were in-serviced on ttihe appropriatie ttiemperattiure per to safte guidelines Correcttive acttions will be mettio ensure ttihe alleged defted does notti occur. 1. All sttiaft inserviced on Mar 24,2011 and ttio be inservice on June 17,2011 regarding appropriattie ttiemperattiure and when ttio ttiake ttiemperattiure and when ttio	by alleged attion ftor ial ttio be ftciency in e ift any wide striurbances CDM 2011 on ing solttihcare are ttio be ftore ttio dining eryliceThe policy sheatti attie tihe serve monittiored antti actti y d again e oft ftoods rattiures daily by attihey are es be	

		IDENTIFICATION NUM		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	IBEK:	A. BUI	LDING	00		LETED
		155191		B. WIN	IG		05/27/2	2011
NAME OF E	PROVIDER OR SUPPLIER			<u>-</u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	NO VIDEN ON SUFFEIER				2210 G	REENTREE NORTH		
WESTMI	NSTER HEALTH CA	ARE CENTER			CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIE	ENCIES		ID	PROVIDER'S PLAN OF CORRECTION	Ī	(X5)
PREFIX		CY MUST BE PERCEDE			PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E RIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INF	ORMATION)		TAG	DEFICIENCY)		DATE
						are recording ttiemperattiur 8 stt	imes	
						per meal and ttihatti ttihese		
						ttiemperattiures meetti ttihe re	quired	
						ttiemperattiure per ttihe serve s	afte	
						guidelines.		
						4. CDM or designee will record		
						ftndings on a daily auditti sheet		
						monttihs and ttihen randomly a		
						ttihat r iny deviattion will be corr	ecttied	
						immediattiely and responsible		
						employee educattiedAuditti and		
						ftndings ttio be reporttied ttio t		
						ttieam in ttihe monttihly meetti	•	
						5. Directtior oft Acttivitties will i	•	
						any residentti concerns coming		
						monttihly residentti council me	_	
						CDM wittih a Residentti Council		
						Concern Form. CDM will respon		
						ttihe appropriattiftorm and retti		
						ftorm ttio ttihe Acttivittiy Direct		
						designee after investtigatting to		
						issue nottittio exceed ftv¢5) day		
						The CDM will be available ttio a		
						questtions regarding ttihe issue		
						ttihe Residentti Council as requ	-	
						ttihe CouncilThe Acttivittiy Direc		
						designee will inttiroduce ttihe I		
						Council Concern Form atti ttihe		
						scheduled Council Meetting ttio		
						inftorm ttihe Council oft Acttior	iaken	
						-		
						Eftecttiveness oft ttihe plan		
						Any revisions needed will be		
						evaluattied by ttihe QA ttied into	-	
						Manager, Consulttiantti Diettici	an and	
						ttihe Administtirattior		
						-		
						Tag F-371: Food Procu	<u>e,</u>	
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete	Event ID:	DTB611	Facility	ID: 000100 If continuation	n sheet Pa	age 33 of 41

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155191	B. WIN	G		05/27/2	011
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			2210 GF	REENTREE NORTH		
	NSTER HEALTH C			L	SVILLE, IN47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	<u> </u>		DATE
					Sttior@Prepare/Serve		
					<u>-Sanittiar</u> y		
					Ceiling Venttis		
					Correcttive acttion ftor ttihose res	<u>ide</u> nttis	
					aftecttied by ttihe alleged deftcien	ісу	
					No residenttis have been aftecttie	d by	
					alleged deftciency. Primary sttiaft		
					have been inttierviewed ftor		
					complainttis oft GI disttiurbandeo	ne	
					have been reporttied		
					Identtifty residenttis who have		
					pottienttial ttio be aftecttied by all	eged	
					deftciency and correcttive acttion		
					ttihose residenttis	<u></u> o.	
					All residenttis have pottienttial ttic	be	
					aftecttied by ttihe alleged deftcien		
					Primary care sttiaft have been	•	
					inttierviewed ttio dettiermine ift a	ny wide	
					spread complainttis oft GI disttiurl	bances	
					and none have been nottiedCDM	ttio	
					in-service sttiaft on June 17,2011 or	n	
					importtiance oft keeping all ventti	s ftree	
					ftrom dustti and debris		
					- Correcttive acttions will be manit	iorod	
					Correcttive acttions will be monitt ttio ensure ttihe alleged deftantti		
					does notti occur.	actti	
					Ceiling ventti was cleaned		
					immediattiely		
					2. Ceiling venttis are on cleaning		
					scheduled ttio be cleaned biweekl	У	
					3. CDM and/or designee will be		
					doing daily rounds ttio ensure all		
					ceiling venttis are ftree ftrom dust	ti	
					4. CDM or designee will record		
					ftndings on a daily auditti sheetti f	Bor	
					monttihs and ttihen randomly after	er	
			1				l

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	(X2) MULTIPLE COI A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/27/2011
	ROVIDER OR SUPPLIER		STREET A 2210 GF	DDRESS, CITY, STATE, ZIP CODE REENTREE NORTH SVILLE, IN47129	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	(X5) COMPLETION DATE
				ttihatany deviattion will be correct immediattiely and responsible employee educattiedAuditti and ftndings ttio be reporttied ttio ttil ttieam in ttihe monttihly meetting - Eftecttiveness oft ttihe plan Any revisions needed will be	ne QA
				evaluattied by ttihe QA ttie Diettician Manager, Consulttiantti Diettician ttihe Administtirattior	·
				Tag F-371: Food Procure Sttior Prepare/Serve -Sanittiary	<u>, </u>
				Hand washing Correcttive acttion ftor ttihose re aftecttied by ttihe alleged deftcie No residenttis have been aftecttie alleged deftciency. Primary sttiaf have been inttierviewed ftor complainttis oft GI disttiurband	ncy ed by t
				Identtifty residenttis who have pottienttial ttio be aftecttied by a deftciency and correcttive acttion ttihose residenttis All residenttis have pottienttial tti aftecttied by ttihe alleged deftcie Primary care stitaft have been inttierviewed ttio dettiermine iff spread complainttis oft GI disttiut and none have been nottiedCDM	o be ncy any wide bances

PRINTED: 06/20/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CO		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPLI	
		155191	A. BUILD! B. WING	ING		05/27/20)11
NAME OF PROV	IDER OR SUPPLIER			STREET AI	DDRESS, CITY, STATE, ZIP CODE		
					REENTREE NORTH		
	TER HEALTH CA	ARE CENTER		CLARKS	SVILLE, IN47129		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	1	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
					in-service sttiaft on June 7,2011 on importtiance oft hand washing he in-service will include tithe policy a procedure ftor hand washing and tappropriattie ttimes in which tito whands. Correcttive acttions will be monittititio ensure tithe alleged deftanttial does notti occur. 1. All sttiaft inservice on June 17,2011. 2. Sttiaft will be monittiored daily the ensure all sttiaft are washing tithe hands appropriattiely and when needed. 3. CDM and/or designee will be doing daily rounds tito ensure all strain from the policy and procedure. 4. CDM or designee will record findings on a daily auditti sheettiff monttihs and tithen randomly after tithat finy deviattion will be correct immediattiely and responsible employee educattied Auditti and findings tio be reporttied tio tithe titeam in tithe monttihly meetting Eftecttiveness of tithe plan Any revisions needed will be evaluattied by tithe QA tite Diettician in tithe Administirattior	and tithe vash ored ctti tio r ttiaft e QA	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155191		(X2) MULTIPL A. BUILDING		NSTRUCTION 00	(X3) DATE S COMPL 05/27/2	ETED	
		155191	B. WING			05/27/2	011
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
WESTMI	NSTER HEALTH CA	ARE CENTER	I		SVILLE, IN47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFI	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0441 SS=E	Infection Control F a safe, sanitary an and to help prever	stablish and maintain an Program designed to provide ad comfortable environment at the development and sease and infection.					
	Program under wh (1) Investigates, coinfections in the fa (2) Decides what pisolation, should bresident; and (3) Maintains a recorrective actions (b) Preventing Spr (1) When the Infect determines that a prevent the spread must isolate the recommunicable dislesions from direct their food, if direct disease. (3) The facility must be communicable dislesions from direct their food, if direct disease.	stablish an Infection Control nich it - ontrols, and prevents cility; orocedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility					
which hand washing is indicated by accepted professional practice. (c) Linens							
	Personnel must ha	andle, store, process and as to prevent the spread of					
	Based on observa	ation and record review,	F0441		F 441 3.1-21(i)(3) 483.65		06/26/2011
	the facility failed	to ensure nurses washed			INFECTION CONTROL, PREVENT SPREAD, LINENS The facility has established and will maintain		
	hands during the	medication pass between					
	_	5 licensed nurses and 1					
	Qualified Medica	ation Aide observed.			an Infection Control Progra		

l '			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
	155191		B. WIN	IG		05/27/2	011
NAME OF PROVIDER OR SUPPLIER			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
While of TROVIDER OR GOTTELER			1	REENTREE NORTH			
WESTM	INSTER HEALTH C	ARE CENTER		CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	This deficient pr	actice affected 1 of 1			designed to provide a safe,		
	resident observe	d in a sample of 16 and 3			sanitary and comfortable		
	of 3 residents in	a supplemental sample of			environment and to help prevent the development ar	nd	
	8 observed recei	ving medications. (transmission of disease an		
	Resident #50, #7	77, #78, #80)			infection. Resident # 50 No		
					actual harm identified to resi	dent	
	Findings include	:			# 50 due to the alleged defic		
	i mamga meraut				practice.The nurse responsit		
	On 05/24/11 at 7	2:39 a.m., Licensed			for the alleged deficient prac	tice ,	
					and all other Licensed and Qualified Aids have been		
		(LPN) #1, was observed			in-serviced on Hand Sanitati	on	
		edications to Resident			with med pass on May 25, 2		
		dministered 16 pills to			Resident # 77 No actual ha		
	1	put on gloves and placed			identified to resident # 77 du		
	the resident's hea	aring aids in her ears.			the alleged deficient practice		
	Without washing	g her hands, using hand			nurse responsible for the alle deficient practice, and all otl		
	sanitizer or chan	ging gloves, she put eye			Licensed and Qualified Aids		
	drops in both of	the resident's eyes.			been in-serviced on Hand	nave	
					Sanitation with med pass on	May	
	On 05/25/11 bet	ween 5:27 a.m. and 5:42			25, 2011. Resident # 78 N		
	a.m., LPN #2, w	as observed to administer			actual harm identified to resi		
	1 '	tesident #77. The LPN			# 78 due to the alleged defic practice. The nurse responsit		
		cations in a cup and			for the alleged deficient prac		
	1 -	ent's room. The LPN			and all other Licensed and	,	
		of the bed and assisted the			Qualified Aids have been		
		he medications. The			in-serviced on Hand Sanitati		
		the medication cart and			with med pass on May 25, 2		
					Resident # 80 No actual ha identified to resident # 80 du		
	1	tion for Resident #78			the alleged deficient practice		
	1	his hands or using hand			nurse responsible for the alle		
		ntered the resident's room			deficient practice, and all other		
		of the bed and assisted the			Licensed and Qualified Aids	have	
		he medication. He again			been in-serviced on Hand	May	
	returned to the n	nedication cart and			Sanitation with med pass on 25, 2011. To identify other		
	prepared medica	tion for Resident # 80.			resident's having the poten		
	He entered the re	esident's room and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 00			COMPL	ETED
		155191	B. WIN			05/27/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2					
WESTMINSTER HEALTH CARE CENTER			1	REENTREE NORTH			
WESTIM	INSTER HEALTH C	ARE CENTER		CLARK	SVILLE, IN47129		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	assisted the resid	lent to take the			to be affected by the allege		
	medication. The	nurse failed to wash his			deficient practice: All reside		
	hands or use han	d sanitizer between			have the potential to be affect		
	Residents #77, #				by the alleged deficient pract		
	Testaches #77, #	70 did #00.			Primary care staff was in-ser on Hand Sanitation on May 2		
	005/27/11 -4.9	0.55			2011 by the SCC and all prin		
		3:55 a.m., in interview			care staff will be in-serviced		
		lopment Coordinator			June 15th and June 16th 20°		
	(SDC) and revie	w of the			the Director of Nursing and tl	he	
	Handwashing/H	and Hygiene provided by			Staff Development Coordinate		
	the SDC at this t	ime, she indicated during			on June 22nd and June 24th		
	the medication p	ass hands are to be			2011 on the policy and proce	dure	
	washed or instant sanitizer is to be used				for Hand Sanitation. The corrective action will be		
	between resident				monitored to ensure the		
					alleged deficient practice	loos	
	Under general gi				not recur: All nurse manage		
	"Handwashing/F				complete monthly audits of F		
	Policy/Procedure	e" " Bullet #4 : " If hands			Sanitation with a med pass	iaiia	
	are not visibly so	oiled, use an			observation on each nurse a	nd	
	alcohol-based ha	and rub for all the			qma. An audit will be comple	eted	
	following situati	ons:			by the Director of Nursing		
		contact with residents;			monthly with the findings of t		
		ng sterile gloves;			med pass and hand sanitation	n	
		ming any non-surgical			observation. The staff		
	_	- ·			development coordinator will complete two random hand		
	invasive procedu				sanitations observations wee	klv	
	d. Before prepar	ring or handling			and will audit the hand sanita	•	
	medications;"				observations monthly.Any		
					observation of inappropriate	hand	
	3.1-18(1)				sanitation with med pass will		
					immediately corrected and th		
					responsible staff member wil	l be	
					re-educated on proper hand sanitation. The measures pu	ıt in	
					place to ensure the alleged		
					deficient practice does not		
					recur: All primary care staff	were	
					in-serviced on proper hand		
					P - P		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	A. BUILDING B. WING	00	COMPLETED 05/27/2011
	ROVIDER OR SUPPLIER		STREET A 2210 G	ADDRESS, CITY, STATE, ZIP CODE REENTREE NORTH SVILLE, IN47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				sanitation on May 25th 2011 SDC and will be re-in-service proper hand sanitation by the Director of Nursing on June and 16th 2011. The SDC will give all primary care staff are in-service on June 22nd and 2011 on proper hand sanitation and the pass observation each nurse and qma. An auxill be completed by the Director of Nursing monthly with the findings of the med pass and hand sanitation observations staff development coordinate complete two random hand sanitations observations we and will audit the hand sanitations observations we and will audit the hand sanitation with med pass will immediately corrected and the responsible staff member were-educated on proper hand sanitation. The Director of Norn designee will report the find from the Quality Assurance Committee. The SDC will rethe findings of the two random weekly hand sanitation audit the Quality Assurance Commonthly basis. Effectiveness of plant Quality Assurance committed monthly basis to assure the alleged deficient practice do not recur. Any revisions or changes will be reviewed by	ed on e 15th ill also ad d 24th, cion. olete itation n on udit ector d .The or will ekly ation hand I be he ill be ursing nding audits port om ts to mittee e will n on a es

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	(X2) MULTIPLE CO A. BUILDING B. WING	00	I	e survey pleted /2011
	PROVIDER OR SUPPLIER		2210 G	ADDRESS, CITY, STATE, ZIP C REENTREE NORTH (SVILLE, IN47129	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)		(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Quality Assurance C Administrator , DON	Committee,	DATE